RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Department for Medicaid Services

Schedule Date: June 13, 1991

Prepared by
STATE RECORDS BRANCH
Public Records Division
Kentucky Department for Libraries and Archives

Printed with State Funds

RECORDS RETENTION SCHEDULE

Signature Page

Cabinet for Human Resources
Dept. for Medicaid Services
Agency

June 1991
Schedule Date

Unit

Change Date

June 13, 1991
Date Approved by Commission

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APPROVALS

The undersigned approve of the following Records Retention Schedule or Change:

Donald S. Wilson Dep Sec.
Agency Head

6/3/91
Date of Approval

Anne L. Bailey
Agency Records Officer

6-3-91
Date of Approval

Richard Kelly Kelly
State Archivist and Records Administrator
Director, Public Records Division

5/25/1991
Date of Approval

Chairman, Archives and Records Commission

6/13/91
Date of Approval

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The undersigned Public Records Division staff have examined the record items and recommend the disposition as shown:

Kathy Gilliland
Records Analyst/Regional Administrator

5/29/91
Date of Approval

Barbara Teare
Appraisal Archivist

5/29/91
Date of Approval

Diana Meyer
State/Local Records Branch Manager

5/29/91
Date of Approval

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The determination as set forth meets with my approval.

Bob Babbage by Regina Grubbs
Auditor of Public Accounts

6-10-91
Date of Approval

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Medicaid Services

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03999	Kentucky Medicaid/Title XIX State Plan File	This series documents the types of services covered, income and resource standards, eligibility requirements and reimbursement methodologies for each type of service. In accordance with federal regulations governing a state's operation of a Medicaid (Title XIX) Program, Kentucky must submit to the Health Care Financing Administration (HCFA) regional office (Atlanta, GA) a Medicaid State Plan. The Department for Medicaid Services has the responsibility for the operation of Kentucky's Medicaid program. The Department must keep current state plans and correspondence with the appropriate plan submittal forms, with pages being changed, and all obsolete plan pages in a filing manner where previous pages or forms can be reviewed. The regional HCFA office randomly conducts a state plan process review to verify that the state is in compliance. The Medicaid State Plan is changing constantly due to federal regulations, laws, policy issuances, or the state changing its options relating to reimbursement or services. The HCFA office may approve, disapprove or change submitted proposals by the state office. Because of lawsuits, audits or legislative requests, the Department must be able to re-create the state plan as it existed at specific dates.	Series contains: State Plan transmittal submittal form; correspondence related to the submittal; current pre-print pages; obsolete pages; data submitted as backup; text related to (new) federal regulations/state regulations; cost reports; services to be rendered; new drugs added, others no longer allowed; eligibility requirements; contract negotiations/systems monitoring	Agency: P Retain in agency.	Records Center:	Archives Center:
04000	Medicaid Management Information System (MMIS) - (Electronic) (C) KRS 205.175 (V)	This series documents the automated information, storage, retrieval, and claims processing system used to process medical claims accurately and timely and to provide data for most aspects of administering the Kentucky medical assistance program. Federal financial participation requires the operation of this system by states. Through this system, providers of medical services are reimbursed in accordance with the established policy for the services received by recipients. The operation and maintenance of the system is procured through competitive bid through the combined efforts of the Department, the Governor's Office for Technology and the Finance and Administration Cabinet.	Series contains: Names of recipients/providers; recipient/provider Medicaid identification numbers; claim information regarding services rendered, tests, or pharmaceutical needs required; costs of services; amounts of medication prescribed; patient histories; recipient third party/insurance information	Agency: I Delete audited files after five years	Records Center:	Archives Center:

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction
03454	Annual Medical Payment Listing - (1099 Report) (MMIS Printout)	This series documents paid Medicaid claims to providers (doctors' offices, clinics) that have been recorded over a year's time. Each January, Electronic Data System (EDS), a private vendor, creates and forwards an Annual Medical Payment Listing to Medicaid Services. A copy of portions of this report is sent to each individual provider (in the same manner as W2's are submitted to taxpayers). It is retained primarily for the purpose of making information available to providers and to the Office of the Attorney General, Medicaid Fraud Division, for its use in casework. NOTE: EDS receives the Vendor Claim Form (04008) from the provider, who becomes eligible to provide Medicaid services by making application and receiving a Provider number from the Department. EDS inputs the information received. The Department has access to the information from a Telex mini-computer, but is not able to manipulate it.	Series contains: Year reporting; provider name and number; provider's address; yearly amount paid	Agency: 5 Records Center: 5 Archives Center: Transfer to the State Records Center
03638	Contract Monitoring and Claim Processing Assessment Systems File (C) KRS 205.175	This series documents and identifies deficiencies in the claims processing activities of the Fiscal Agent Branch. The branch is required to review a sampling of all adjudicated claims from the previous month and examines and evaluates the accuracy of the Department's claims processing and payments. The contents of this file are copies of the Vendor Claim Form (and all attachments) (04008) and recipient histories, etc. The series represents a new file created from information that already exists. The file aids in correcting deficiencies and audits. Auditors use the file to complete an audit, and will also make use of other agency records not included in the claims processing assessment system file.	Series contains: Provider financial reports-check amounts, month-to-date summary, adjustments, paid/denied claims, returns provider cash report, claims reports and analysis of adjudicated claims; discrepancy report form, design change request forms, copy of statement of payments, paid in full report; sample documentation - claims, recipient and provider eligibility, recipient histories, pricing files; data collected includes: name, address, birth date, social security number, identification number , county code, race, Medicaid history, provider name and number, services rendered by provider, dates of service, provider check amounts, discrepancies, provider financial transactions (payments, funds recouped, payouts, adjustments, refunds)	Agency: 2 Records Center: 3 Archives Center: Transfer to the State Records Center. Destroy after audit

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction
04546	Nurse Aid Training Expense Report and Authorization for Payment File - (For certified Nursing Home facilities) Change Date: 3/14/1996	This series documents the direct reimbursement of nurse aide training costs to Nursing Homes which have been certified by the Department as Medicaid facilities. Kentucky's program for direct reimbursement for nurse aide training began in October 1990, as a requirement of the federal government. Aides are required to complete 75 hours of training using a specific curriculum, based on federal guidelines, developed by the Department. That portion of the training is reimbursable. The costs of in-service (continuing education) training, which also is required by the program, are paid for by the Department on an annual basis, not as a direct reimbursement. Aides can be certified for employment and receive their training at a later date. Direct reimbursement payments are authorized on a monthly basis. Monthly requests are reviewed prior to authorization to ensure that maximum amounts allotted for training are not exceeded. The amount each facility has allotted for direct reimbursement is figured at .45 cents per Medicaid patient day per cost report period.	Series contains: Supporting documentation such as allocation of trainer's salary, trainer's travel costs, trainer's time sheets and payroll history, requisition for checks for employee testing, copies of checks. The file also contains provider name and address; Medicaid provider number; billing for month of; program code; account numbers; organization control number; invoice number; item description; total cost; total amount	Agency: 2 Records Center: 3 Archives Center: Transfer to the State Records Center. Destroy after audit
04550	Provider Tax Collection File Change Date: 3/14/1996	Closed Series: This series was created to document the collection of taxes from Medicaid providers as required by HB 21, which was enacted during the 1991 Special Session of the General Assembly. Providers included medical doctors, dentists, and pharmacies. Tax assessment was based on 50% of the increased fees providers received for delivery of Medicaid services. The taxes collected were placed in a Medicaid account and used to fund general Medicaid benefits. During the 1993 Special Session of the General Assembly, the provider tax was extended to most health care givers, not just those providing Medicaid services. At this time, the responsibility for the collection of the health care provider tax was transferred to the Revenue Cabinet, from the Department for Medicaid Services. (See series 04343 and 04344, Revenue Cabinet retention schedule.)	Series contains: Dunning statement and copy of check remitting tax payment	Agency: I Records Center: 5 Archives Center: Transfer to the State Records Center after all collection efforts have been exhausted. Destroy after audit
04001	Medicaid Provider File (C) KRS 205.175 (V)	This series documents the approval by the Department to allow a provider to serve in that capacity. It serves as a history of the activities of the provider (agreements, correspondence, appeals, federal tax identification numbers, licenses). Medical service providers must be licensed and/or certified by the appropriate agency (Board of Medical Licensure, Board of Nursing). The series also includes non-emergency transportation providers. This means that any licensed driver that transports a patient to and from a treatment may be reimbursed as a provider through the Medicaid program. There are some providers who see few, if any, Medicaid patients, but remain eligible, as well as providers who no longer participate as a provider, but have outstanding claims being processed (i.e., submitted improperly).	Series contains: Enrollment agreements (contracts, information sheets, copies of licenses); correspondence; hospice forms regarding patient information, hospital, drug-related information and benefits; alternative intermediate services letters of appeal, client placement, plans of care, cost worksheets, and nursing notes	Agency: I Records Center: Archives Center: Destroy five years after last claim is processed or after expiration of contract, whichever comes first, and audit

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Medicaid Services

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction
04002	Citicare Project Files Closed Date: 5/1/1991 (C) KRS 205.175	Closed Series - This series documented the Citicare project conducted in Jefferson County. Citicare was a case management program for approximately 48,000 indigent recipients enrolled in the Aid to Families with Dependent Children (AFDC) program. The program began in June 1983 and was discontinued in June, 1984. Lawsuits were filed due to contract discrepancies, and claims filed for services not provided. It is important to note that the discontinuance of the project was an administrative decision, and not related to the legal action that followed. The case was closed May 1, 1991.	Series contains: Medicaid recipient files and printouts indicating claims processed per provider	Agency: 0 Records Center: 5 Archives Center: Transfer to the State Records Center. Destroy five years after final disposition of the case. NOTE: Citicare project guidelines will be retained. Transfer to the State
04003	Medicaid Recipient Eligibility Income File (C) KRS 205.175 (V)	This series documents the determination of a recipient's eligibility for Medicaid services, based on the individual's income. The Department for Social Insurance accepts and processes the applications for Medicaid Services and determines how much of a recipient's income must be applied toward the cost of their medical care. Each time the recipient's income changes (increases or decreases), another eligibility form must be completed and a new eligibility calculated. The series is utilized in Medicaid fraud investigations (Office of the Attorney General, Medicaid Fraud and Abuse Control Division).	Series contains: Medicaid number; program/county; client's name; birthday; provider number; admission/discharge/death date; level of care; family status; income computation (unearned Income; earned income; total; deductions-personal needs allowance, health insurance, incurred medical expenses, total; Veteran's Administration aid; third party payments); available income; worker code; caseload code; update date	Agency: I Records Center: Archives Center: Destroy five years after eligibility has expired, and audit
04004	Lock-in Program Case File and Performance Review (C) KRS 205.175	This series documents the utilization patterns of recipients by categorizing their medical needs and the services provided, then examines and summarizes those patterns. The federal government mandates a review of at least 40 recipients be monitored per quarter for fifteen months. A history of the recipients' fifteen-month utilization activities is reviewed by analysts in the branch. Medication and treatment regimes are compared with the diagnoses. The mandated review provides the annual "systems performance review," the comparison/summary report generated by the Medicaid Management Information System (04000). The performance review compares utilization patterns of recipients by categorizing data in "peer groups." Data are arranged so that a "norm" is established. Cases for those recipients that who deviate from the established norm are reviewed, based upon excesses of drugs, visits to physicians and dollars paid by Medicaid. Recipients who are utilizing services in excess of their medical needs are placed on "lock-in" to one physician and one pharmacy of their choice. The recipients are on lock-in for one year and are reviewed to check improvement in utilization patterns so that the individual may be removed from that status. The performance review is maintained with the case files.	Series contains: Recipient letters; review analysis and summary; lock-in recipient update records; rationale for lock-in; selection of physician and pharmacy format; card for recommendations and comments; patient history codes; pharmacy history; recipient exception profile; case data cover sheet; exception profile review; vendor claim forms; beneficiary history report; lock-in case summary; and recipient drug profile	Agency: 3 Records Center: 2 Archives Center: Transfer to the State Records Center. Destroy after audit

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Medicaid Services

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction
04005	Medical Review Files of Providers and Performance Review (C) KRS 205.175 Change Date: 6/12/1997	This series documents the practice and service patterns of providers, then examines and summarizes those patterns. The federal government mandates, under the terms of 42 CFR 430-456, that a review of at least 40 providers be monitored per quarter for 15 months. The 40 providers are selected through a statistical computer-based program which organizes practice and patterns of the providers, establishing norms and listing those providers deviating from that norm. Claim histories of the selected providers for the 15-month period are reviewed. Aberrant patterns are identified. Analysts examine the files to determine why a deviation may exist. Recipients may be contacted to determine whether a particular service was provided. On-site reviews may be conducted. Medical necessity and appropriateness of care are determined. Accuracy of the payment system and claims processing function are also reviewed. The Performance Review is maintained with the case files. This series also is used to prosecute fraud cases and for the collection of money owed to the state.	Series contains: Activity report/date; questionnaire of services; case data cover sheet; exception profile review; provider summary profile report (exceptions); chronological list of significant case actions; case review actions; letter to provider; claims detail request/report; provider on-site information sheet; state requested financial transactions update; statement form; correspondence; surveillance and utilization review report	Agency: 3 Records Center: 7 Archives Center: Transfer to the State Records Center. Destroy after audit
04006	Non-Emergency Medical Transportation Authorization File (C) KRS 205.175	This series documents the pre-authorization of payment for routine medical transportation for eligible Medicaid recipients, which allows for reimbursement to the provider of the transportation. The form must be requested in advance by the recipient The information is keyed in and ready for processing once the provider has verified the distance and the provider and the recipient have signed the form. Each week the Department of Social Insurance field office transmits this information to Electronic Data Systems (EDS) for the processing of checks.	Series contains: Name of recipient; name of the provider (service); destination(s); charges and check or voucher number(s)	Agency: 3 Records Center: Archives Center: Destroy after audit
04007	Annual Cost Report	This series documents the working file used to determine reimbursement allowances each year, and year-end cost settlements for program providers and facilities. The rates are figured by annual operating cost of a facility, administrative needs, drugs/pharmaceutical needs, records of payments, appeals and correspondence between the facility and the Medicaid program.	Series contains: Name of facility; statistical page; certificate of ownership; cost reports; route slip worksheet; rate adjustments; tickler file; credits and adjustments; mass adjustments; desk review-pre-audit analysis	Agency: 3 Records Center: 2 Archives Center: Transfer to the State Records Center. Destroy after audit

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction
04535	Home and Community Based Waiver Client Record File (C) KRS 205.175 (V)	This series documents client eligibility for Home and Community Based Waiver services and identifies the services authorized for payment by the Department. The program allows for clients to live at home when they have the right kind of care and support from family and friends. The program pays for home health services that will keep a patient from living in a nursing home. Services include general household activities (meal preparation, cleaning), personal care, respite care, minor home adaptations (rails around a tub or commode, not major home repairs), and respiratory therapy services. Financial applications are completed at the local Social Insurance office. The Patient Access and Assessment Branch evaluates client eligibility and monitors services for authorized clients, until terminated. When a provider is changed, the client must re-apply for eligibility. The provider bills the Department for payment.	Series contains: Eligibility forms; selection of community services; discharge form; assessment form used by provider with condition of patient; request for home adaptation equipment; confirmation notice; plans for treatment and reassessments	Agency: I Records Center: 5 Archives Center: Transfer to the State Records Center after termination. Destroy after audit
04538	Kentucky Medicaid Alternative Intermediate Services File (C) KRS 205.175 (V)	This series documents client eligibility for the Alternative Intermediate Services program and identifies the services authorized for payment by the Department. The services are generally for mentally retarded or developmentally challenged patients. Comprehensive Care and private agencies provide case management, residential (facility) care, respite care, physical therapy, occupational therapy, speech and therapeutic recreation, among others. All providers are certified by the Department. The Patient Assessment Branch evaluates client eligibility and monitors services for authorized clients, until terminated.	Series contains: Confirmation notice-level of care assigned by peer review organization; client choice of community services; placement form; Medicaid approval letter; individual habilitation plan-6 month plan for services; review of on-site services form; prior authorization for services; addendum-to change service plan; incident report; termination letter; psychological and psychosocial history and medical information	Agency: I Records Center: 5 Archives Center: Transfer to the State Records Center after termination. Destroy after audit
04539	Medicaid Nurse Aide Training Request for Exemption File - (Grandfathering requests) Closed Date: 6/30/1991 (C) KRS 205.175 Change Date: 9/14/1995	This series documented the request for exemption for the training and testing required of nurse aides at facilities where Medicaid services were provided. A nurse aide is one who provides nursing or nursing related services to residents of a facility, but does not include an individual who is a licensed health professional or a volunteer who works without monetary compensation. The nurse aides applied for exemptions, in hopes of being "grandfathered in," and would not have to complete other training and testing requirements. The Department is no longer grandfathering nurse aides. Grandfathering was considered for nurse aides already working when the program began. Now all nurse aides must go through routine testing and training, without exception. The option to request such exemptions stopped in June 1991.	Series contains: Request for exemption; and correspondence approving or denying request	Agency: 4 Records Center: 1 Archives Center: Transfer to the State Records Center. Destroy after audit

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Cabinet for Health and Family Services

Medicaid Services

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction
04640	Case Mix Appeal Record File - (Re-considerations of Medicaid reimbursement rates) (C) KRS 61.878 (1) (a) Medical Information Change Date: 6/12/1997	This series documents the records which are provided by Medicaid long term care facility providers who are asking for a re-consideration of the reimbursement received for Medicaid services. The process of re-consideration is referred to as a case mix appeal. The reimbursement rate a facility is eligible for is figured by applying a weight to all Medicaid patient records who are in long term care, i.e., all cases are mixed together and a weight applied (hence the name case mix appeal). The reimbursement rate is the average of all weights. The Healthcare Review Corporation, a private contractor, makes a visit to each facility and completes an initial assessment for reimbursement. If the facility is dissatisfied, it can request a re-consideration of the rate by the Corporation. The Corporation may than increase, decrease or keep the same reimbursement rate. The last recourse for the provider is to appeal to a special panel within the Cabinet, made up of a Medicaid case mix staff person, a representative from the Nursing Association, and a nurse from the Department for Medicaid Services.	Series contains: Patient information; copies of initial assessment and re-consideration (if applicable); doctor's orders; diagnosis sheets; minimum date set (federal form); care plans; nursing assessment; histories; physicals; and lab tests	Agency: 1 Records Center: 4 Archives Center: Transfer to the State Records Center
05329	Pharmacy Program Prior Authorization File - (For payment of drugs to Medicaid recipients) (C) KRS 194A.060 Change Date: 3/14/2002	This series documents the pre-authorization of payment for drugs for Medicaid recipients and provides approval for reimbursement to the provider of the drugs. The provider must request the approval in advance of the dispensing of the drugs, as required in 907 KAR 1:019.	Series contains: Pre-authorization forms; pharmacy reports and surveys; and related correspondence	Agency: 1 Records Center: 4 Archives Center: Transfer to the State Records Center. Destroy after audit
05385	Recovery Case File (C) KRS 194A.060 Change Date: 6/12/2003	This series documents the recovery of Medicaid benefits recipients received while under treatment for injuries related to an accident, such as a motor vehicle accident or a slip and fall in a store or shopping area. If, as a result of the accident, there is an insurance settlement, the individual must pay back the Medicaid funds spent in the treatment of the injury or medical condition. Failure to do so can result in further legal action.	Series contains: Release of medical records; letters of representation from the attorney; copies of histories and paid claims; copies of checks and audit sheets; related correspondence	Agency: 1 Records Center: 4 Archives Center: Transfer to the State Records Center. Destroy after audit

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Medicaid Services
Home Health Services

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
1209.1	Bank Statements Change Date: 4/1/1980			Agency: 5	Records Center:	Archives Center:
				Destroy after audit		
1209.2	Budget Memoranda Change Date: 4/1/1980			Agency: 5	Records Center:	Archives Center:
				Destroy after audit		
1209.3	Cancelled Checks Change Date: 4/1/1980			Agency: 5	Records Center:	Archives Center:
				Destroy after audit		
1209.4	Check Register Change Date: 4/1/1980			Agency: 5	Records Center:	Archives Center:
				Destroy after audit		
1209.5	Insurance Billings Change Date: 4/1/1980			Agency: 5	Records Center:	Archives Center:
				Destroy after audit		
1209.6	Home Health Records Change Date: 4/1/1980			Agency: 3	Records Center:	Archives Center:
				Destroy		

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Medicaid Services

Reimbursement Operations

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
04008	Vendor Claim File (C) KRS 205.175 Change Date: 6/12/1997	This series documents services rendered by a provider and a claim for payment that is filed with the Department. The payment form is sent directly to the Unisys Corporation for processing and for conversion to an imaging system. The series is used to complete audits, for the prosecution of fraud cases, and to make adjustments in payments. Previously, the series was microfilmed by Electronic Data Systems (EDS).	Series contains: Recipient name; Medicaid identification number; date of service; nature of charges/procedures; provider name; identification number; address; signature; statement of payment	Agency: 10 Destroy after audit	Records Center:	Archives Center: